

- Maternal-Infant Health Program -

MATERNAL RISKS, INTERVENTIONS AND OUTCOMES MATRIX

IMMEDIATE PROGRAM GOAL: To improve the health and well being of Medicaid-eligible pregnant women and infants through a system-wide process to:

- Screen all Medicaid-eligible pregnant women for key risk factors.
- Assign risk stratification.
- Deliver targeted interventions
- Measure specific outcomes.

LONG TERM PROGRAM GOAL: To reduce maternal and infant morbidity and mortality.

The MIHP targets high-risk women. All women are enrolled in the program unless they opt out. At a minimum, the MIHP will provide all women with basic MCH information, including but not limited to how to contact the program, nutrition/WIC, symptoms of preterm labor, parenting readiness, family planning, safe sleep, etc. Health education classes (childbirth, breastfeeding, parenting, preventive health, etc) will be an integral part of this program; communities may consider tailoring content to satisfy community needs/goals.

Risk stratification will be determined through the use of uniform screening tool (under development) that allows women to be stratified at low- or high-risk levels. Interventions vary by risk factor and stratification level. Coordination with the OB provider and/or the PCP or health plan is expected and necessary for women with any identified risk(s).

The MIHP is population-based and will ultimately link evidence-based program expectations with outcomes measurement. Initially, providers will be required to document processes to engage the highest risk women through WIC and other strategies (e.g., CHW, outreach in high-risk neighborhoods/schools, etc.). It is expected that these strategies will increase both the engagement and retention of high-risk women.

	PRENATAL RISK FACTOR (CORE DOMAIN OF CARE)	NEGATIVE SCREEN	POSITIVE SCREEN/ RISK STRATIFICATION LEVEL	INTERVENTION	MIHP MEASUREMENT	MIHP PROGRAM OUTCOMES
1.	Inadequate Perinatal Care	<p>In care and no access issues identified. Care established by 20 weeks.</p> <p><i>All women given transportation information.</i></p>	<p>Low: In care at the time of assessment, but:</p> <ul style="list-style-type: none"> • began care at or beyond 20 weeks gestation, or • access issues identified. <p>High: No care established care beyond 20 weeks.</p>	<ul style="list-style-type: none"> • Coordinate with OB provider and/or health plan. • Phone support PRN to ensure appointments are scheduled and kept. <ul style="list-style-type: none"> • Coordinate with OB provider and/or health plan. • Schedule appointment; provide phone support prn to ensure appointments kept. • One counseling session to cover importance of care and basic pregnancy health issues. 	<ul style="list-style-type: none"> • Documented process to refer program enrollees to prenatal care. • Percentage of program enrollees initiating prenatal care at care <20 weeks and ≥20 weeks.* 	Increase timely utilization of perinatal care
2.	Smoking/Tobacco Use	<p>No tobacco use.</p> <p><i>All women given information on the effects of tobacco use/second hand smoke during pregnancy and infancy. Information will also be provided regarding smoking cessation programs in the community that partners could attend.</i></p>	<p>Low: Smoking one pack per day or less.</p> <p>High: Smoking more than one pack per day.</p>	<ul style="list-style-type: none"> • Coordinate with OB provider and/or health plan. • Ensure that 5 A intervention is delivered. If not directly delivered, the MIHP provider follows progress with a minimum of 1-2 phone calls. • Based on assessment, if client is determined to be unready to change, provide educational materials and reassess: <ul style="list-style-type: none"> ◦ in 30 days if less than 28 weeks gestation ◦ in 14 days if greater than 28 weeks gestation. • If client is still unready to change, ensure that client and OB provider know how to obtain cessation services if she becomes ready. <ul style="list-style-type: none"> • Coordinate efforts with OB provider and/or health plan. • Ensures 5 A intervention delivered within 14 days of screening. • Based on assessment, if client is determined to be unready to change, deliver intensive education/counseling weekly for four weeks. • If client is still unready to change, refer for additional counseling in the community and/or educate client and coordinate with PCP or OB provider to initiate pharmacological therapy. • Pharmacological therapy should be considered for all women in this group who are unable to quit. 	<ul style="list-style-type: none"> • Percentage of enrolled smokers screened. • Percentage of enrolled smokers who quit. • Percentage of enrolled smokers who decrease smoking. 	<ul style="list-style-type: none"> • Increase maternal screening for smoking/tobacco use • Reduce maternal smoking/tobacco use

* Year 1 measurement will be the baseline measurement

	PRENATAL RISK FACTORS	SCREEN NEGATIVE	RISK STRATIFICATION LEVEL	INTERVENTION	MIHP PROVIDER MEASUREMENT	MIHP PROGRAM OUTCOMES
3.	Substance Abuse	No substance use.	Low: Client previously or currently in substance abuse treatment.	<ul style="list-style-type: none"> Coordinate efforts with OB provider and/or health plan. Initiate bi-weekly to monthly contact to ensure treatment is successful. 	<ul style="list-style-type: none"> Percentage of enrolled substance users screened. Percentage of substance users in treatment.* 	Increase maternal substance abuse screening and intervention
		<i>All women given basic educational materials regarding substance use and treatment.</i>	High: Client admits to alcohol and/or substance use.	<ul style="list-style-type: none"> Coordinate efforts with OB provider and/or health plan. Assess readiness to change. <ul style="list-style-type: none"> If client is ready to change, refer for treatment. If client is unready to change, contact weekly for 4-6 weeks to work on readiness to change. 		
4.	Unintended Pregnancy/ Inter-Pregnancy Interval**	Wanted/planned pregnancy and XX interval.	Low: Client chose to become pregnant but has a short inter-pregnancy interval.	<ul style="list-style-type: none"> Coordinate efforts with OB provider and/or health plan. Provide educational counseling and materials regarding risk of short inter-pregnancy interval. Review signs of pre-term labor. Contact client bi-weekly beginning at 24-26 weeks to review signs of pre-term labor. 	<ul style="list-style-type: none"> Percentage of women who access family planning services. Percentage of women with documentation of contraceptive plan. 	<ul style="list-style-type: none"> Decrease unintended pregnancy rate Increase rate of pregnancies occurring at appropriate inter-pregnancy interval
		<i>All women given family planning information and information regarding ideal inter-pregnancy interval.</i>	High: Client did not want to become pregnant.	<ul style="list-style-type: none"> Coordinate efforts with OB provider and/or health plan. Provide a minimum of two educational/counseling sessions. At 36 weeks, review and document client's contraceptive plan. Contact client 2-4 weeks postpartum to assess maternal-infant bonding and review contraceptive plan. If short inter-pregnancy interval present, contact client bi-weekly beginning at 24-26 weeks gestation to review signs of pre-term labor. 		

* Year 1 measurement will be the baseline measurement

	PRENATAL RISK FACTORS	SCREEN NEGATIVE	RISK STRATIFICATION LEVEL	INTERVENTION	MIHP PROVIDER MEASUREMENT	MIHP PROGRAM OUTCOMES
5.	Depression/Behavioral Health	Negative screen for depression.	Low: Edinburgh depression tool results in a mild score, or woman is already being treated for depression.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan (with appropriate client consent). Educate client on the benefits of exercise to treat mood disorders. Refer for counseling and/or support group. Initiate monthly contact with client to reassess (Edinburgh) and provide support. 	<ul style="list-style-type: none"> Percentage of women screened for depression. Percentage of women referred for treatment. Percentage of women with pharmacological treatment.* 	Increase maternal depression screening and intervention
		<i>All women given information regarding signs of perinatal depression and treatment.</i>	High: Edinburgh depression tool results in a moderate or severe score.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Educate woman on the benefits of exercise to treat mood disorders. Refer for and coordinate pharmacological treatment with the OB provider and/or CMH (with appropriate client consent). Refer for counseling and/or support group. Initiate weekly contact with client until stable and then bi-weekly to monthly. Develop and document emergency plan. 		
6.	Domestic Violence	Negative screen.	Low: Client has been in a previously abusive relationship.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Review and discuss personal safety. Provide client with community-specific intervention information/resources. 	<ul style="list-style-type: none"> Percentage of enrolled women screened for domestic violence. Percentage of women with a domestic violence intervention.* 	Increase domestic violence screening and intervention
		<i>All women given DV/IPV information and community intervention information.</i>	High: Client in a current abusive relationship.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Initiate DV intervention referral. Develop, review, and document personal safety reviewed and emergency plan. Initiate weekly contact until stable. Monthly program contact thereafter. 		

* Year 1 measurement will be the baseline measurement

	PRENATAL RISK FACTORS	SCREEN NEGATIVE	RISK STRATIFICATION LEVEL	INTERVENTION	MIHP PROVIDER MEASUREMENT	MIHP PROGRAM OUTCOMES
7.	Chronic Disease	No chronic disease(s) identified.	Low: Client understands and adheres to her chronic disease treatment plan or is enrolled in a health plan DM program.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. If not already enrolled, refer to available health plan DM program(s). Contact client monthly to every trimester to ensure client is stable. 	<ul style="list-style-type: none"> Percentage of enrolled women screened for chronic disease. Percentage of enrolled women with chronic disease with documentation of care coordination. 	Increase coordination of care for treatment of chronic disease
			High: Client does not understand her chronic disease treatment plan, is not adhering to the plan, or has an ED or IP admission in the six months prior to assessment for the identified condition(s).	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Refer to available health plan DM program(s) and coordinate with DM case management. If no DM program available, contact client weekly until stable, then bi-weekly to monthly. 		
8.	Unfulfilled Basic Need(s)	No basic needs identified. <i>All women given community specific resource\e information.</i>	Low: Client has stable housing, but other basic needs are at risk (i.e. infrequent food supply concerns, utilities, etc.).	<ul style="list-style-type: none"> Coordinate efforts with OB provider and/or health plan. Initiate community referrals. Contact client weekly to bi-weekly until stable, then monthly. 	Documentation of provider's referral process.	Program enrollees' basic needs are met.
			High: Client's housing unstable and/or food supply threatened.	<ul style="list-style-type: none"> Coordinate efforts with OB provider and/or health plan. Initiate community referrals. Contact client weekly until stable, then monthly. 		
9.	Transportation Needs	No transportation issues identified. <i>All women given information regarding transportation services.</i>	Low: Access to transportation the only identified risk.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Refer to transportation services, prn. 	<ul style="list-style-type: none"> Percentage of enrolled women with documented transportation needs. Percentage of women with documented transportation needs who receive transportation services. 	Increase access to and utilization of transportation services
			High: Transportation identified in addition to one or more other risk factors.	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Include transportation access in other interventions. 		

	PRENATAL RISK FACTORS	SCREEN NEGATIVE	RISK STRATIFICATION LEVEL	INTERVENTION	MIHP PROVIDER MEASUREMENT	MIHP PROGRAM OUTCOMES
10.	Inadequate Nutrition	<p>Client enrolled in WIC.</p> <p><i>All women given prenatal vitamin information emphasizing the importance of PN vitamins during preconception.</i></p> <p><i>All women given breastfeeding information tailored to level of interest and community resources.</i></p>	<p>Low: Not enrolled in WIC and BMI within normal limits.</p> <p>High: Inadequate or inappropriate weight gain or low/high BMI.</p>	<ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Enroll client in WIC. Initiate 1-2 contacts to discuss community resources and/or nutritional information, prn. Phone follow-up x 2. <ul style="list-style-type: none"> Coordinate with the OB provider and/or health plan. Assess readiness to change. <ul style="list-style-type: none"> If ready to change, arrange 2-4 sessions for high-risk nutritional counseling. If unready to change, contact 2-3 times to address readiness issues and then bi-weekly phone calls x 4 for reassessment. If client becomes ready to change, arrange for 2-4 sessions for high risk nutritional counseling. 	<ul style="list-style-type: none"> Percentage of women enrolled in WIC. Percentage of clients enrolled in WIC during first trimester.* Percentage of infants breastfed.* 	<p>Improve and increase adequate maternal nutrition</p>
OTHER AREAS OF EVALUATION						
	Client Satisfaction				<ul style="list-style-type: none"> Client satisfaction – to be assessed using satisfaction survey instrument developed and administered by MDCH. 	<ul style="list-style-type: none"> Increased client satisfaction Increased client retention
	Provider Satisfaction				<ul style="list-style-type: none"> Provider satisfaction – to be assessed using satisfaction survey instrument developed and administered by MDCH. 	<ul style="list-style-type: none"> Increased provider satisfaction

* Year 1 measurement will be the baseline measurement